



PATIENT INFORMATION

Patient's Name: _____
 Date: _____ Gender: _____ School: (if applicable) _____
 Nickname: _____ Hobbies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Birth Date: _____
 Who is your dentist? _____
 Whom may we thank for referring you to our office? _____
 Any family members treated in our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____
 Residence Address: _____ City: _____ State: _____ Zip: _____
 Mailing Address _____ City: _____ State: _____ Zip: _____
 How long at this address? _____ Home Phone: _____ Work Phone: _____
 Previous Address (if less than 3 yrs. at current) _____
 Social Security # _____ Birth Date _____ Relationship to Patient _____
 Employer _____ How long? _____ Occupation _____
 Spouse's Name _____ Relationship to Patient _____
 Employer _____ How long? _____ Occupation _____
 Social Security # _____ Birth Date _____ Work Phone _____

FAMILY INFORMATION

(If patient is a minor)

The following information is requested so that we can communicate properly with the people involved with your child's treatment.

With whom does the patient live (custodial parent)? _____

Who should receive routine information about treatment progress? _____

Other adults we should know about:

Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____

Patient's Siblings (Names & Ages) _____

We are sorry that we cannot accept divorce decrees as assignments or responsibility for a child's orthodontic bills. The custodial parent is financially responsible for the services and should seek any reimbursement from the other parent.

ORTHODONTIC INSURANCE INFORMATION

(Fill out this section only if your insurance provides **Orthodontic** benefits)

Insured's Name _____ Insured's ID # _____

Insurance Company _____ Group # _____ Employer _____

Insurance Co. Address _____ Phone # _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's ID # _____

Insurance Company _____ Group # _____ Employer _____

Insurance Co. Address _____ Phone # _____

Patient's Name: _____

MEDICAL HISTORY

Patient's Physician _____ Date Last Seen _____

<u>Yes</u>	<u>No</u>	
<input type="radio"/>	<input type="radio"/>	Has the patient been under the care of a physician during the last two years? If yes, for what conditions? _____
<input type="radio"/>	<input type="radio"/>	Does the patient have a current medical problem? _____
<input type="radio"/>	<input type="radio"/>	Is the patient currently taking or using any pills, medications, or drugs? If yes, please list: _____
<input type="radio"/>	<input type="radio"/>	Has the patient had an unusual reaction to any medication? _____
<input type="radio"/>	<input type="radio"/>	Has the patient ever had an injury to the head, face, or mouth? _____
<input type="radio"/>	<input type="radio"/>	Has the patient ever had a serious illness? _____
<input type="radio"/>	<input type="radio"/>	Has the patient ever had any surgery or been hospitalized? _____
<input type="radio"/>	<input type="radio"/>	Has the patient had the tonsils or adenoids removed? _____ Age _____
<input type="radio"/>	<input type="radio"/>	Is the patient or could the patient possible be pregnant? _____
<input type="radio"/>	<input type="radio"/>	Does the patient have any congenital (born with) problems? _____
<input type="radio"/>	<input type="radio"/>	Has the patient ever been diagnosed with a heart murmur? _____
<input type="radio"/>	<input type="radio"/>	Has a doctor/dentist recommended that the patient take antibiotics prior to dental work? _____
<input type="radio"/>	<input type="radio"/>	Is the patient allergic to anything (food, medications, etc.)? If yes, please list. _____

Has the patient ever been diagnosed or treated for any of the following (circle all that apply):

Diabetes	Bone disease	Tuberculosis	Prolonged bleeding
Fainting/Dizziness	Endocrine problem	Ulcers	Cerebral Palsy
Arthritis	Epilepsy	Cancer	Bleeding disorder
Anemia	Hepatitis	Low/High blood pressure	Recurrent pain
Heart condition	Pneumonia	Joint replacement	Multiple sclerosis
Kidney problem	AIDS or HIV	Emotional problem	Nervous disorder
Liver problem	Asthma	Communication disability	Growth disorder
Breathing trouble	Rheumatic fever	Learning disability	Allergies

DENTAL HISTORY

Patient's Dentist: _____ Date Late Seen _____

What is the main reason for seeking Orthodontic treatment? _____

<u>Yes</u>	<u>No</u>	
<input type="radio"/>	<input type="radio"/>	Is the patient currently undergoing any dental treatment? _____
<input type="radio"/>	<input type="radio"/>	Does the patient every have temperature sensitive teeth or bleeding gums? _____
<input type="radio"/>	<input type="radio"/>	Has the patient seen a periodontist, endodontist, or oral surgeon? _____
<input type="radio"/>	<input type="radio"/>	Has the patient had previous orthodontic treatment or consultation? When? _____
<input type="radio"/>	<input type="radio"/>	Has the patient had any teeth extracted? Why? _____
<input type="radio"/>	<input type="radio"/>	Has the patient every injured or broken any teeth? _____
<input type="radio"/>	<input type="radio"/>	Does the patient have any missing or extra teeth? _____
<input type="radio"/>	<input type="radio"/>	Does the patient have any difficulty eating, speaking, or swallowing? _____
<input type="radio"/>	<input type="radio"/>	Does the patient have any habits such as thumb sucking or nail biting? _____
<input type="radio"/>	<input type="radio"/>	Does the patient have any dental or facial pain? _____
<input type="radio"/>	<input type="radio"/>	Does the patient's jaw joint make noises or hurt? _____
<input type="radio"/>	<input type="radio"/>	Has the patient's jaw ever locked open or closed? _____
<input type="radio"/>	<input type="radio"/>	Does the patient habitually grind or clench the teeth together? _____
<input type="radio"/>	<input type="radio"/>	Does the patient normally breathe with the lips apart and through their mouth? _____
<input type="radio"/>	<input type="radio"/>	Is the patient aware of any swellings or growths in the mouth or face? _____
<input type="radio"/>	<input type="radio"/>	Is the patient especially concerned about orthodontic treatment? _____
<input type="radio"/>	<input type="radio"/>	Has any member of the patient's family ever had orthodontic treatment? _____
<input type="radio"/>	<input type="radio"/>	Is there any other medical or dental information we should know? _____

Signature (Parent or guardian, if patient is a minor) _____ Date _____

Doctor's initials _____ Date _____